

CROSS Region
County Rural Offices of Social Services
FY 2017 Annual Report



Geographic Area: Clarke, Decatur, Lucas, Marion, Monroe, Ringgold, and Wayne Counties

Approved by CROSS Governing Board: 12/1/2017

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Introduction

CROSS Region was formed under Iowa Code Chapter 28E to create a Mental Health and Disability Service Region in compliance with Iowa Code 331.390.

In compliance with IAC 441-25 the CROSS Region Management Plan includes three parts: Annual Service and Budget Plan, Annual Report and Policies and Procedures Manual.

This report provides an analysis of data concerning services managed for the fiscal year including July 1, 2016 through June 30, 2017. The CROSS management plans and annual report are available on the CROSS Website www.crossmentalhealth.org and DHS websites <http://dhs.iowa.gov>. They are also available in each member county's community services office.

The Annual report reflects our third year of regionalization. The CROSS Region met the third year with direction and purpose. The Board elected to expand services, initiate new innovative services, and looked forward to the potential of meeting the State's ask for commitment to Children's services. The Board acted in a cohesive fashion to meet the challenges of yet another year of whirlwind changes and system instability.

Senate File 504 was passed by the legislature April 17, 2018. This piece of legislation changed the funding structure for regions by creating a maximum regional per capita levy rate. The legislation required member counties of the region to lower their levy rates if they were above the new maximum per capita rate but did not require all member counties of a region to increase to the regional maximum per capita levy rate.

This has created new challenges for the Governing Board members to set aside individual county perspectives and take the collaborative regional approach. The challenge rests with the fact that regions do not set levy rates for individual member counties; the member county Boards of Supervisors set the levy rates. If a member county's Board of Supervisors is not agreeable to increasing the levy amount to match the other region members, then the collaboration required for regions to function is potentially jeopardized.

Senate File 504 impacted the region's levy revenues by decreasing the levy rate in six of the member counties and increasing the levy rate in one-member county. The member county with the allowable increase has chosen not to increase their mental health levy, so the region has experienced a loss of \$212,294 to the MHDS fund for FY18. This has created a new challenge for the region to operate as a cohesive collaborative entity, but the Governing Board has met the challenge and continues to operate as a cohesive entity.

Senate File 504 also requires regions to limit cash flow to 25% (for smaller regions) beginning fiscal year 2020 to be applied to fiscal year 2022. The 25% cash flow limit will be calculated on the gross expenditures of each member county. The fund balance in each member county that exceeds the 25% shall be reduced to the 25% with the excess cash flow allocated to property tax relief. The 25% limit will not meet the cash flow needs of the region as property

taxes are accrued in September and March, but those levy dollars do not enter the mental health fund accounts until October and April. The regions will likely experience cash flow shortfalls. Encumbrance is an accounting method regions are exploring as an option to improve the cash flow shortfall, but it is unclear how encumbrance will be viewed by the agencies responsible for oversight of this new legislated financial construct.

In addition to restructuring the regional revenue system, senate file 504 requires regions to hold workgroups beginning July 1, 2017 incorporating stakeholders from hospitals, judicial system, law enforcement, MCOs, mental health providers, crisis service providers, substance abuse providers, NAMI, and other entities as appropriate to address the needs of individuals with complex needs in the areas of mental health, disability, and substance abuse disorder. These workgroups were used to form the region's plan for service development and investment of fund balances to span FY18, FY19, and FY20. The CROSS plan can be accessed at the region's Website: www.crossmentalhealth.org.

The Region's gratitude goes out to the providers, stakeholders, county employees with regional duties and the Governing Board for seizing the opportunity to increase collaboration and provide their input, tireless work and the sometimes-uncomfortable journey to create a cohesive regional system that makes the vision for the Region a reality.

Reflecting back on this past year of operation we realize we have once again accomplished so much for the residents we serve, and, while the future remains a changing and uncertain landscape, we are positive we can achieve more, do better, and rejoice knowing our public service attitude and hard labors have benefited those in need.

Individuals Served in Fiscal Year 2017:

This section includes:

- the number of individuals in each diagnostic category funded for each service
- unduplicated count of individuals funded by age and diagnostic category

Persons Served by Age Group and by Primary Diagnosis

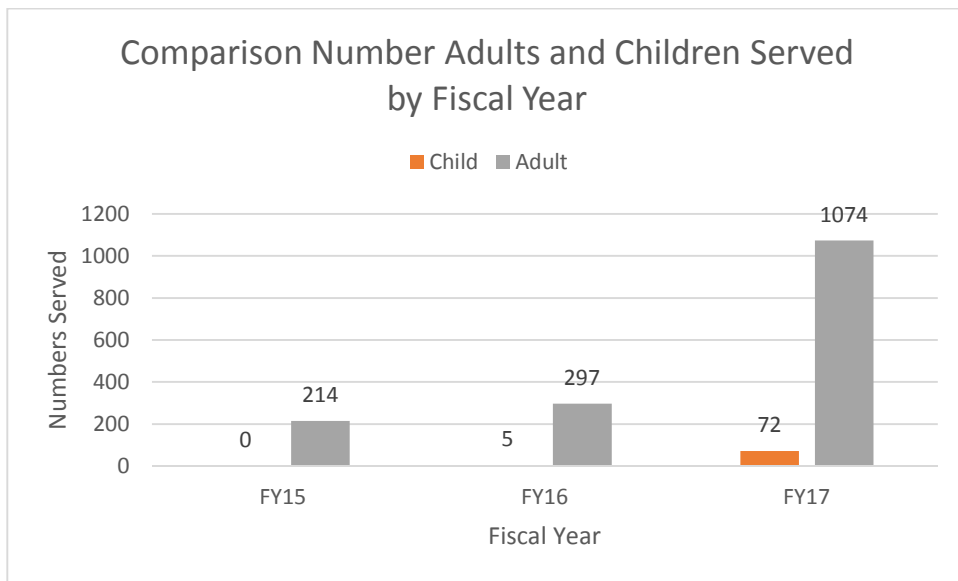
This chart lists the number of individuals funded for each service by diagnosis.

FY 2017	CountyRuralOfficesofSocialServices MHDS Region	MI (40)		ID (42)		DD (43)		BI (47)		Other		Total
		A	C	A	C	A	C	A	C	A	C	
Core												
	Treatment											
43301	Evaluation (Non Crisis) - Assessment and Evaluation	1										1
73319	Other Priv./Public Hospitals - Inpatient per diem charges	1										1
42306	Psychotherapeutic Treatment - Medication Prescribing	2										2
42305	Psychotherapeutic Treatment - Outpatient	11										11
71319	State MHI Inpatient - Per diem charges	1	1									2
	Basic Crisis Response											
44301	Crisis Evaluation	196	25									221
	Support for Community Living											
32320	Support Services - Home Health Aides	5		1								6
32329	Support Services - Supported Community Living	29		6		1						36
	Support For Employment											
50367	Day Habilitation	2		3								5
50368	Voc/Day - Individual Supported Employment			1		2						3
50362	Voc/Day - Prevocational Services					1						1
	Recovery Services											
	Service Coordination											
	Core Evidence Based Treatment											
32396	Supported Housing			1								1
	Core Subtotals:	248	26	12		4						290
Mandated												
74XXX	CommitmentRelated (except 301)	137	6	2								145
46319	Iowa Medical and Classification Center (Oakdale)	3										3
75XXX	Mental health advocate	138	2	6								146
	Mandated Subtotals:	278	8	8								294
Core Plus												
	Comprehensive Facility and Community Based Treatment											
44313	Crisis Stabilization Residential Service (CSRS)	7										7
	Sub-Acute Services											
	Justice System Involved Services											
46305	Mental Health Services in Jails	36	2									38
	Additional Core Evidence Based Treatment											
	Core Plus Subtotals:	43	2									45

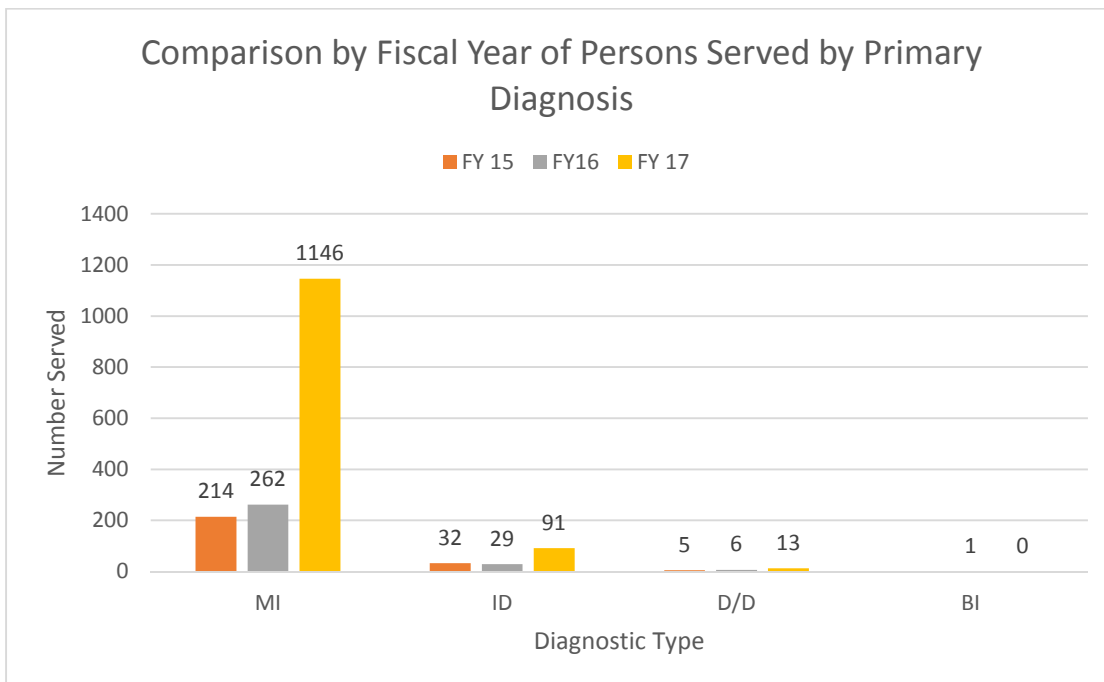
Cont. Persons Served by Age Group and Primary Diagnosis

FY 2017	County Rural Offices of Social Services MHDS Region	MI (40)		ID (42)		DD (43)		BI (47)		Other		Total
		A	C	A	C	A	C	A	C	A	C	
	Other Informational Services											
	Community Living Support Services											
	Support for Community Living											
	Service Coordination											
33345	Basic Needs - Ongoing Rent Subsidy	1										1
33399	Basic Needs - Other	9										9
33340	Basic Needs - Rent Payments	1										1
63329	Comm Based Settings (1-5 Bed) - Supported Community Living	1										1
23376	Crisis Care Coordination - Coordination Services	207	26									233
41305	Physiological Treatment - Outpatient	1										1
41306	Physiological Treatment - Prescription Medicine/Vaccines	13										13
63XXX	RCF 1-5 beds	1										1
22XXX	Services management	199	10	42								251
32326	Support Services - Guardian/Conservator	1		1								2
31XXX	Transportation	30		4		5						39
50399	Voc/Day - Day Habilitation			2								2
50361	Vocational Skills Training	1		1								2
	Community Living Support Services Subtotals:	465	36	50		5						556
	Congregate Services											
64329	Comm Based Settings (6+ Beds) - Supported Community Living	1										1
64XXX	RCF-6 and over beds	31		2								33
50360	Voc/Day - Sheltered Workshop Services	7		19		4						30
	Congregate Services Subtotals:	39		21		4						64
	Administration											
11XXX	Direct Administration									45		45
	Administration Subtotals:									45		45
	Uncategorized											
73399	Other Priv./Public Hospitals - Other (non inpatient charges)	1										1
	Uncategorized Subtotals:	1										1
	Regional Totals:	1074	72	91		13				45		1295

The following chart illustrates an increase in services to children, primarily through tele-psych services for evaluation and assessment.



This graph illustrates the growth in services and utilization between fiscal years FY15, FY16, FY17.

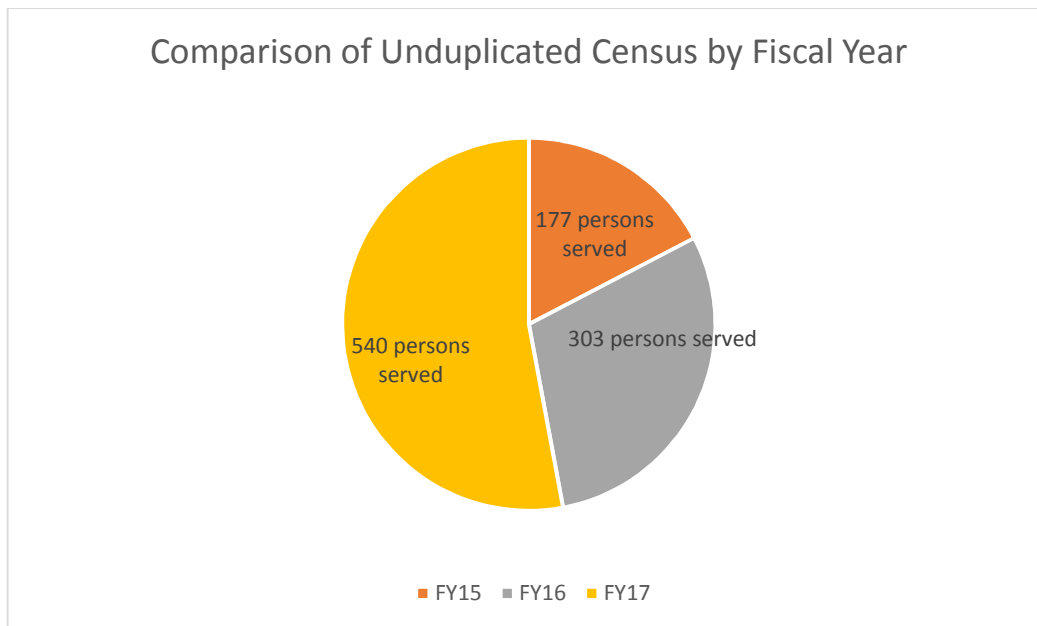


Unduplicated Count of Adults and Children by Diagnosis

The chart below shows the unduplicated count of individuals funded by age group and diagnosis

Disability Group	Children	Adult	Unduplicated Total	DG
	0	1	1	
Mental Illness	35	450	485	40
Mental Illness, Intellectual Disabilities	0	13	13	40, 42
Mental Illness, Intellectual Disabilities, MH/DD General Administration	0	1	1	40, 42, 44
Mental Illness, MH/DD General Administration	0	14	14	40, 44
Intellectual Disabilities	0	18	18	42
Intellectual Disabilities, Other Developmental Disabilities	0	1	1	42, 43
Other Developmental Disabilities	0	7	7	43
Total	35	505	540	99

The chart below shows the increase in unduplicated census between fiscal years: FY15, FY16, FY17. Expanding tele-psych services and starting ACT accounts for much of the increase.



Total Expenditures by Disability and Chart of Account Type

FY 2017 Actual GAAP	XXX MHDS Region	MI (40)	ID(42)	DD(43)	BI (47)	Admin (44)	Total
Core Domains							
COA	Treatment						
		\$					\$
43301	Assessment & evaluation	325					325
		\$					\$
42305	Mental health outpatient therapy	5,908					5,908
		\$					\$
42306	Medication prescribing & management	973					973
		\$					\$
71319	Mental health inpatient therapy-MHI	2,369					2,369
		\$					\$
73319	Mental health inpatient therapy	51,570					51,570
	Basic Crisis Response						
32322	Personal emergency response system						\$ -
		\$					\$
44301	Crisis evaluation	74,997					74,997
44305	24 hour access to crisis response						\$ -
	Support for Community Living						
		\$	\$				\$
32320	Home health aide	4,540	2,627				7,167
32325	Respite						\$ -
32328	Home & vehicle modifications						\$ -
		\$	\$	\$			\$
32329	Supported community living	97,701	211,243	4,020			312,964
	Support for Employment						
				\$	\$		\$
50362	Prevocational services			8,047	-		8,047
		\$	\$				\$
50367	Day habilitation	49,877	3,986				53,864
50364	Job development						\$ -
			\$	\$			\$
50368	Supported employment		48	2,608			2,656
50369	Group Supported employment-enclave						\$ -
	Recovery Services						
45323	Family support						\$ -
45366	Peer support						\$ -
	Service Coordination						
21375	Case management						\$ -
24376	Health homes						\$ -
	Core Evidenced Based Treatment						
		\$					\$
04422	Education & Training Services - provider competency	765					765
			\$				\$
32396	Supported housing		5,536				5,536
		\$					\$
42398	Assertive community treatment (ACT)	434,140					434,140
45373	Family psychoeducation						\$ -
	Core Domains Total	\$ 723,166	\$ 223,441	\$ 14,675	\$ -		\$ 961,282

FY 2017 Actual GAAP	XXX MHDS Region	MI (40)	ID(42)	DD(43)	BI (47)	Admin (44)	Total
Mandated Services							
46319	Oakdale	\$ 6,510					\$ 6,510
72319	State resource centers	\$ -					\$ -
74XXX	Commitment related (except 301)	\$ 50,654	\$ 56				\$ 50,709
75XXX	Mental health advocate	\$ 33,916	\$ 365				\$ 34,282
	Mandated Services Total	\$ 91,080	\$ 421	\$ -	\$ -		\$ 91,501
Additional Core Domains							
	Comprehensive Facility & Community Based Crisis Services						
44346	24 hour crisis line	\$ 63,297					\$ 63,297
44366	Warm line						\$ -
44307	Mobile response						\$ -
44302	23 hour crisis observation & holding						\$ -
44312	Crisis Stabilization community-based services						\$ -
44313	Crisis Stabilization residential services	\$ 31,250					\$ 31,250
	Sub-Acute Services						
63309	Subacute services-1-5 beds						\$ -
64309	Subacute services-6 and over beds						\$ -
	Justice system-involved services						
46305	Mental health services in jails	\$ 14,088					\$ 14,088
25xxx	Coordination services						\$ -
46422	Crisis prevention training	\$ 1,022					\$ 1,022
46425	Mental health court related costs						\$ -
74301	Civil commitment prescreening evaluation						\$ -
46399	Justice system-involved services-other						\$ -
	Additional Core Evidenced based treatment						
42397	Psychiatric rehabilitation (IPR)						\$ -
42366	Peer self-help drop-in centers						\$ -
	Additional Core Domains Total	\$ 109,657	\$ -	\$ -	\$ -		\$ 109,657

FY 2017 Actual GAAP	CROSS MHDS Region	MI (40)	ID(42)	DD(43)	BI (47)	Admin (44)	Total
Other Informational Services							
03371	Information & referral						\$ -
04372	Planning and/or Consultation (client related)						\$ -
04377	Provider Incentive Payment						\$ -
04429	Planning and Management Consultants (non-client related)						\$ -
04399	Consultation Other						\$ -
05373	Public education	\$ 21,706					\$ 21,706
	Other Informational Services Total	\$ 21,706	\$ -	\$ -	\$ -		\$ 21,706
Other Community Living Support Services							
06399	Academic services						\$ -
22XXX	Services management	\$ 467,103	\$ 29,150				\$ 496,253
23376	Crisis care coordination	\$ 81,974					\$ 81,974
23399	Crisis care coordination other						\$ -
24399	Health home other						\$ -
31XXX	Transportation	\$ 58,432	\$ 9,093	\$ 11,574			\$ 79,099
32321	Chore services						\$ -
32326	Guardian/conservator	\$ 830	\$ 450				\$ 1,280
32327	Representative payee						\$ -
32399	Other support						\$ -
32335	CDAC						\$ -
33330	Mobile meals						\$ -
33340	Rent payments (time limited)	\$ 2,800					\$ 2,800
33345	Ongoing rent subsidy	\$ 6,361					\$ 6,361
33399	Other basic needs	\$ 3,273					\$ 3,273
41305	Physiological outpatient treatment	\$ 100					\$ 100
41306	Prescription meds	\$ 8,424					\$ 8,424
41307	In-home nursing						\$ -
41308	Health supplies						\$ -
41399	Other physiological treatment						\$ -
42309	Partial hospitalization						\$ -
42310	Transitional living program						\$ -
42363	Day treatment						\$ -
42396	Community support programs						\$ -
42399	Other psychotherapeutic treatment						\$ -
43399	Other non-crisis evaluation						\$ -

44304	Emergency care						\$ -
44399	Other crisis services						\$ -
45399	Other family & peer support						\$ -
50361	Vocational skills training	\$ 92	\$ 35				\$ 127
50365	Supported education						\$ -
50399	Other vocational & day services		\$ 12,221				\$ 12,221
63XXX	RCF 1-5 beds	\$ 25,187					\$ 25,187
63XXX	ICF 1-5 beds						\$ -
63329	SCL 1-5 beds	\$ 50,748					\$ 50,748
63399	Other 1-5 beds						\$ -
	Other Comm Living Support Services Total	\$ 705,325	\$ 50,949	\$ 11,574	\$ -		\$ 767,848

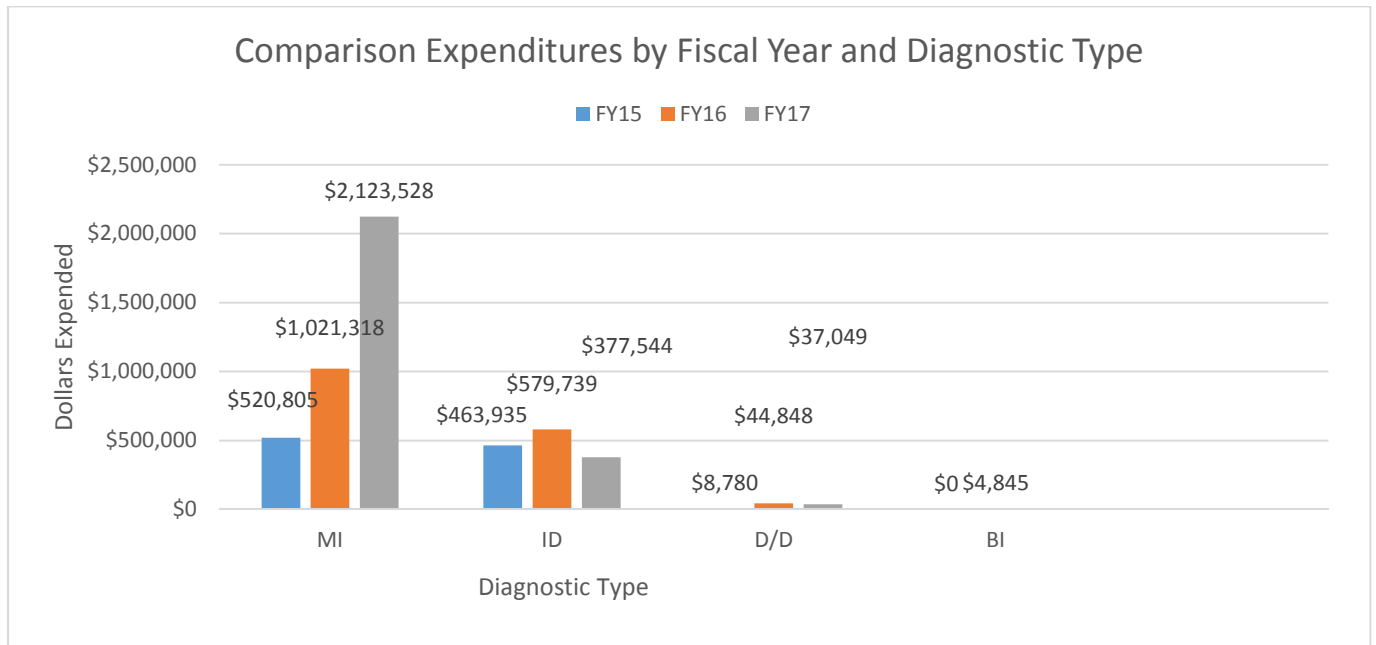
FY 2017 Actual GAAP	XXX MHDS Region	MI (40)	ID(42)	DD(43)	BI (47)	Admin (44)	Total
Other Congregate Services							
50360	Work services (work activity/sheltered work)	\$ 42,013	\$ 70,702	\$ 10,800			\$ 123,515
64XXX	RCF 6 and over beds	\$ 422,736	\$ 32,033				\$ 454,769
64XXX	ICF 6 and over beds						\$ -
64329	SCL 6 and over beds	\$ 7,875					\$ 7,875
64399	Other 6 and over beds						\$ -
	Other Congregate Services Total	\$ 472,624	\$ 102,735	\$ 10,800	\$ -		\$ 586,159
Administration							
11XXX	Direct Administration					273077	\$ 273,077
12XXX	Purchased Administration					13558	\$ 13,558
	Administration Total					\$ 286,635	\$ 286,635
	Regional Totals	\$ 2,123,528	\$ 377,545	\$ 37,049	\$ -	\$ 286,635	\$ 2,824,787.30

(45XX- XXX)County Provided Case Management							\$ -
(46XX- XXX)County Provided Services							\$ -

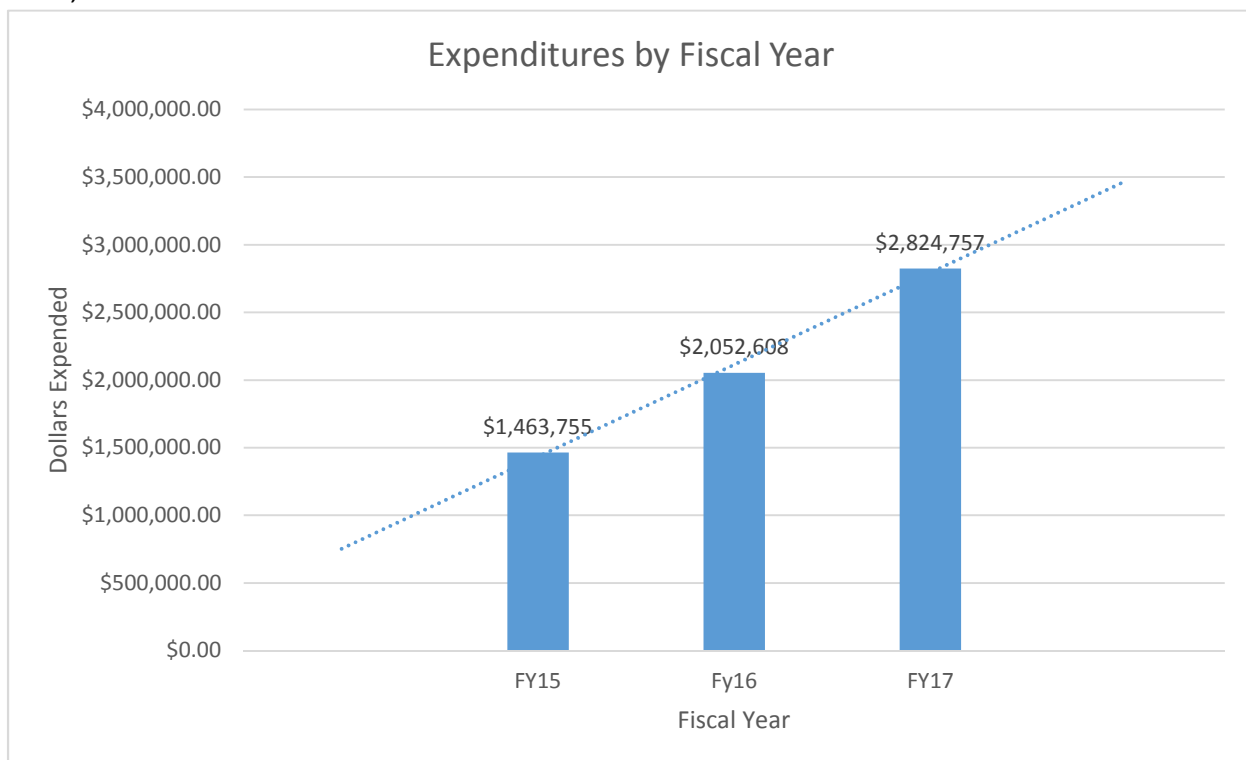
	Regional Grand Total						\$ 2,824,787.30
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Transfer Numbers *Do Not Include in Total Expenditures		
13951	Distribution to MHDS regional fiscal agent from member county	\$ 1,035,472
14951	MHDS fiscal agent reimbursement to MHDS regional member county	\$ 68,000

The following graph depicts the comparison of expenditures by diagnosis over the fiscal years FY15, FY16, and FY17. The region added ACT and expanded tele-psych services in FY17 which accounts for the increase in expenditures and utilization in FY17.



The Chart below depicts the increase in expenditures by fiscal year, comparing FY15, FY16, FY17.



REVENUES

FY 2017 Actuals	CROSS Region		
Revenues			
	Projected Fund Balance as of 6/30/16		\$ 4,867,430
	Local/Regional Funds		\$ 3,140,122
10XX	Property Tax Levied	2,923,263	
12XX	Other County Taxes	2775	
16XX	Utility Tax Replacement Excise Taxes	138719	
4XXX- 5XXX	Charges for Services	-315	
60XX	Interest		
6XX	Use of Money & Property		
25XX	Other Governmental Revenues	39962	
8XX	Miscellaneous	12018	
26XX		23700	
92XX	Proceeds /Gen Fixed assets sales		
	State Funds		\$ 270,630.00
21XX	State Tax Credits	204249	
22XX	Other State Replacement Credits	65026	
2250	MHDS Equalization		
24XX	State/Federal pass thru Revenue		
2644	MHDS Allowed Growth // State Gen. Funds		
2645	State Payment Program		
29XX	Payment in Lieu of taxes	1355	
	Federal Funds		\$ -
2344	Social services block grant		
2345	Medicaid		
	Other		
	Total Revenues		\$ 3,410,732.00

Total Funds Available for FY17	\$ 8,278,162
FY17 Accrual Regional Expenditures	\$ 2,824,787
Region's Accrual Fund Balance as of 6/30/17	\$ 5,453,375

Member County Levies

County	2014 Est. Pop.	47.28 Per Capita Levy	Base Year Expenditure Levy	FY17 Max Levy	FY17 Actual Levy	Actual Levy Per Capita
Clarke	9217	435,780.00	430,559.00	430,559.00	430,559.00	46.71357275
Decatur	8263	390,675.00	321,858.00	321,858.00	321,858.00	38.95171245
Lucas	8701	411,383.00	441,861.00	411,383.00	411,383.00	47.27996782
Marion	33365	1,577,497.00	1,089,896.00	1,089,896.00	1,089,896.00	32.66584744
Monroe	8001	378,287.00	340,278.00	340,278.00	340,278.00	42.52943382
Ringgold	5051	238,811.00	342,082.00	238,811.00	238,811.00	47.27994457
Wayne	6395	302,356.00	254,099.00	254,099.00	254,099.00	39.73401095
Region	78993	3,734,789.00	3,220,633.00	3,086,884.00	3,086,884.00	39.07794362

Outcomes

Service Progress by Core, Additional core, and EBP

Core Services continue to be met throughout the region. Additional Core Services for 24-hour crisis hotline, 23-hour holding, and crisis observation with Mary Greeley were maintained while other services were initiated or expanded in FYE17.

CRISIS SERVICES

24 Hour crisis hotline

The Region explored several crisis line vendors both nationally and locally. The Region was able to contract with Foundation 2 to provide crisis line support for the entire Region. Foundation 2 meets the Iowa Code 441-24.24 standards by becoming chapter 24 accredited this year. Foundation 2, which went live July 1, 2016 met with local providers to obtain referral information for the CROSS Region. The service coordinators have put much work into promoting the crisis line through public education efforts, school assemblies, local clubs, churches, and business associations. The crisis line is promoted in local theaters, newspapers and posters. The Region averages 6 calls a month to the crisis line which has been expanded to limited hours of Text and Chat access Monday through Friday 8-4. Future planning is to expand Chat and Text to 24/7 availability.

The Board added Assertive Community Treatment, Crisis Residential Services, expanded pre-commitment tele-psych screenings and bed finding to all member county hospitals. The Board enhanced jail mental health services to member county jails in need of the service, began the Stepping Up initiative throughout the member counties and initiated development of jail diversion services in each member county and funded CIT trainings for two officers. Training staff were expanded for Mental Health First Aide, NAMI trainings, and C-3 De-escalation.

- The Region published an RFP for an Assertive Community Treatment Program in June 2017 and awarded the RFP to Resources for Human Development in August 2017 to provide ACT services to all seven-member counties. The first clients were admitted in May 2017 with the program serving 10 individuals by the end of June 2017.
- Permanent Supportive Housing Model is attached to the ACT program. This model provides a housing subsidy for individuals using ACT who enter the program homeless or who are low income and rent is more than 40% of their income.
- The Region Board added new service by contracting with Genesis Development to provide citizens of CROSS access to the nine-bed residential crisis unit. This was a collaborative effort with the Heart of Iowa Region and we send Darci Alt, CEO of that region, a special thank-you for opening a resource.
- Pre-commitment Tele-psych services through ITP, Integrated Telehealth Partners, were expanded to include all eight-member county hospitals.

- Jail services were enhanced and expanded by placing tele-psych through ITP with member county jails lacking the service. The National Stepping Up Initiative to reduce the number of individuals with mental illness in jails was adopted by the Board and each member county was asked to adopt the Stepping Up resolution. We have met that goal. Each member county developed a Stepping Up workgroup to begin the process of identifying needs and development of diversion services.
- Trainer availability for Mental Health First Aid, NAMI programming family to family, and C3 De-escalation were achieved.

Region Program Outcomes

Assertive Community Treatment (ACT)

CROSS ACT RHD is the first rural ACT Team in Iowa.

ACT is an evidenced-based practice that delivers a community-based, specialized, psychiatric professional team that includes a psychiatrist, nurse practitioner, licensed master social worker, registered nurse, housing specialist, substance abuse therapist, peer support specialist and employment specialist to provide extended care to individuals with severe mental illness who are at risk of repeated hospitalization or who have had difficulty staying in treatment. It is a service delivery model designed to provide an integrated approach to care for persons with severe mental illness or dual diagnosis in their homes and community.

Date	Activity	Funding	# Client Referrals	Total Number of participants admitted to program
2/28/2017	Office procurement, equipment, program director hired	\$43,350.00	0	
2/28/2017	Monthly Service block grant – salaries, training of new staff	\$195,395.00	0	
4/30/2017	Continued hiring of staff, (psychiatrist, therapist, R.N.) Assessment/evaluation of referrals		4	4
5/31/2017	Continued hiring of staff, (Housing/employment specialist) Assessment/evaluation of referrals		6	10
6/30/2017	Continue staff development, assessment /evaluation of referrals	\$195,395.00	6	10 – 6 being processed
Totals		\$434,140.00	16 referrals	10 admitted

Rural ACT teams differ from urban teams in several distinct ways and have a slightly different fidelity scale. Rural teams by their very definition span large geographical areas, have a lower client/staff ratio, and are challenged with finding professional staff. Our team uses technology wherever possible to close those gaps and bring the team together to provide the intensity of service and integrated approach needed for a successful ACT team.

GO TO WWW.RHD.ORG to view one of our success stories and learn how ACT impacts lives. For this report ACT was only open for two months so statistical information is very limited. By the end of June 30, 2017, the team had admitted 10 individuals.

The ACT Team is funded by a block grant through the region for initial start-up costs with partial funding for year 2. While ACT is a Medicaid reimbursed service the floor rate, \$51.07 a day per member is for 5 days a week. To meet fidelity the ACT team operates 7 days a week and is on call 24hours a day 7-day a week. Legislative action is needed to change the 5-day a week payment structure to a 7-day week payment structure. The State has had a goal of 22 ACT teams across the State. New start-ups cannot perform to fidelity on a base rate of \$51.07 a day for 5 days a week.

The Region also paired a permanent supportive housing model with ACT. This model provides housing subsidy for individuals in the program who are homeless or do not have enough resources to afford safe housing.

Crisis Residential Services

In February of 2017 the Region added crisis residential services to the array of crisis services available for individuals served by the region on a fee for service basis. A total of three individuals utilized the service during the remaining four months of the fiscal year for an average length of stay of 3.6 days.

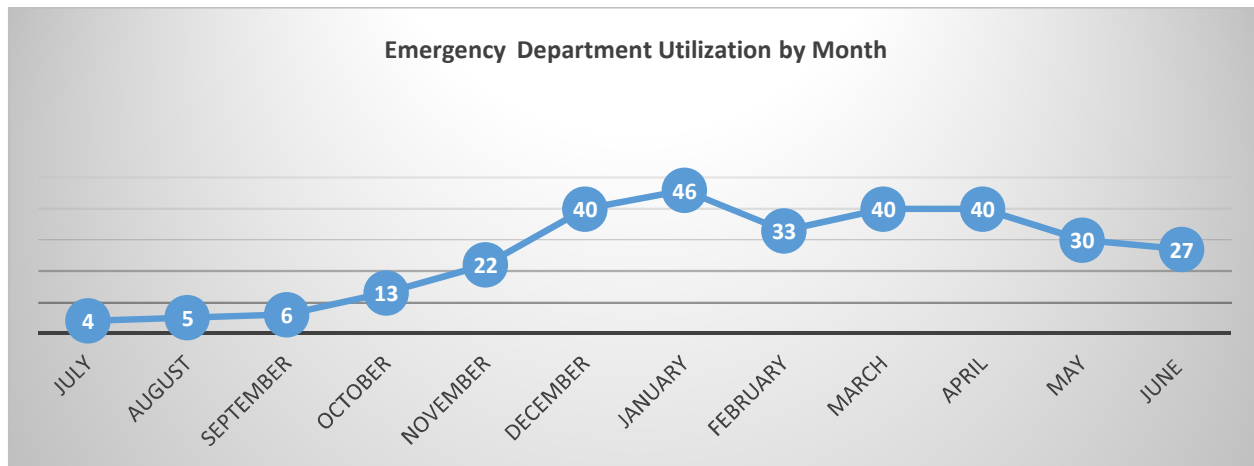
Tele-psychiatry for Hospitals and Jails

Tele-psychiatry is a service that links individuals with a psychiatrist via a two-way connection through the internet. CROSS Region's rural counties rely on their county hospitals for access to pre-commitment screenings, but the Emergency Department staff and physicians did not have access to psychiatrists to assist in the screening process or medication management support. The other complication was the time and staff resources it took to find an inpatient bed if a committal was indicated.

The Region first contracted with Integrated Telehealth Partners at the end of fiscal year 2016 with the intention to offer the service to all the hospitals operating within the Region. We began FYE17 with 3 hospitals on board and achieved our goal to bring on all 8 hospitals in May 2017. It is a 3 to 6-month process to bring a hospital on board for this service. The tele-psych psychiatrists must be licensed for Iowa and credentialed for each hospital. Fiscal year 2017 was our first full year of data collection and will begin establishing a baseline for this service.

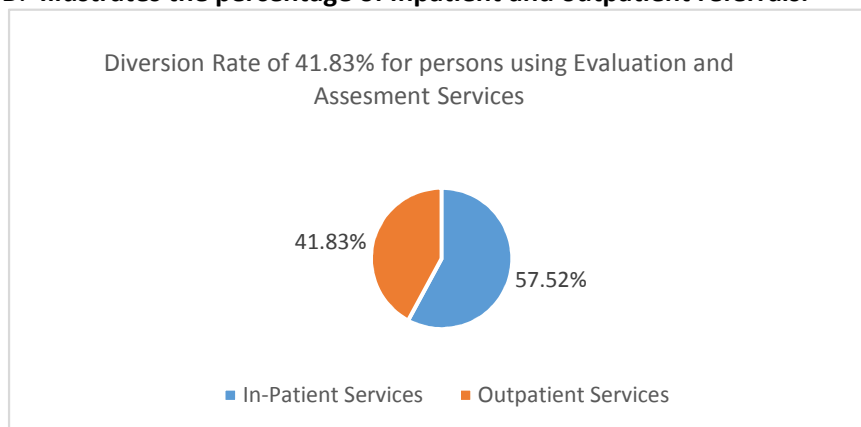
The graphs below illustrate utilization of the service for pre-committal evaluation and the dispensation of those evaluations to inpatient care or outpatient services.

Graph A. Illustrates the total number of evaluations per month throughout the region. The rise in evaluations beginning in October is due to more hospitals coming on board to use the service. All 8 hospitals are live starting May 2017. There was a total of 306 evaluations completed. The median wait time for the year to locate an inpatient bed was 4.48 hours and 5 minutes.



Of the 306 referrals for pre-screening 176 received inpatient treatment, 128 were diverted to outpatient treatment and 2 left the ED against medical advice.

Graph B. Illustrates the percentage of inpatient and outpatient referrals.



Tele-psych in Jails

The total number of available jail beds in the CROSS Region is 227. The region wanted to respond to the needs of several of our county jails requesting psychiatric care that did not involve transporting inmates. There are six operational jails in the region. Two of the jails already contracted services for tele-psych. The other four jails accepted the offer to have ITP provide tele-psych in their jails. 52 inmates utilized the service in FY17. Sheriffs have reported concerns of over utilization by inmates, wait times and medication costs. The region is working with ITP and the Sheriffs to find solutions to these concerns.

Transportation ~ Committal and Voluntary Residential Crisis Services

Responding to access needs to utilize crisis residential beds and the strain on local Sheriffs' departments in supplying transportation to inpatient facilities more than an hour away due to the closing of Clarinda and Mt. Pleasant facilities has proved problematic. *(anecdotally, reports received by the region were deputies being engaged in transport up to 8 hours a day).* There were also reports of two transports being in progress to Council Bluffs *(145 miles, 2hours and 32min, one way)* and Cedar Rapids *(198miles, 2hours and 52min one way)* from the same county resulting in only one officer to cover the county. The Region entered into a contract with Central Iowa Juvenile Detention Center(CIJD) in April 2017 to provide transportation to meet both access needs. Utilization of the service is at the discretion of the local Sheriff departments. The availability of this alternative form of transporting individuals to inpatient facilities received a mixed reception. The concerns voiced were:

1. The time it takes for a driver to arrive for the transport will increase the time in the ED dept. CIJD has agreed to hire local drivers as demand increases to reduce response time.
2. Use of CIJD transportation reduces the overtime for deputies and they rely on the extra income.

CIJD has been utilized by the Sheriffs' departments sporadically and is showing increase utilization in FY2018. The Region also uses CIJD to provide transport of individuals needing crisis residential services at Hope Wellness Center located in Woodward, Iowa. The transportation is available to and from the facility and is on a voluntary basis. The three admissions to Hope Wellness Center utilized CIJD transportation.

Since this service was only available beginning April 2017 there is insufficient data to enter into this report on response times and utilization.

Stepping Up

Stepping Up is the national initiative for counties to reduce the number of individuals with mental illness in jails. The Region has encouraged and collaborated with all member counties to participate in this initiative and as of September 2017 all seven counties have approved Stepping Up resolutions. The first counties to embrace the initiative came on board in January 2017. Regional staff have worked hard to bring together committee members, perform assessments and engage law enforcement. At the end of the fiscal year 5, the 7-member counties had approved resolutions by their Board of Supervisors and "committees formed". The group is currently addressing barriers to data collection, development of re-entry programs, educating law enforcement on resource availability and trainings for deputies and staff. As part of this initiative the Region was able to send two officers to Crisis Intervention Training located in Iowa City by the Johnston County Metro Team, May 2017.

Trainings and other Initiatives

Law Enforcement

In addition to CIT training for law enforcement, on April 6th 2017 the region brought Daniel Flaherty, Attorney at Law, who specializes in mental health committal law in Polk County to present to the Region's judiciary, law enforcement, hospitals and county attorneys. 25 attended the training. Bob Vandepol, MSW also provided law enforcement training throughout the region on verbal de-escalation and psychological First Aid. Three Sheriff's Departments agencies participated.

Law Enforcement & Providers

C3 De-escalation is a promising practice based on brain research. The C3's represents Calm, Circuit, and Connection. The techniques used in C3 intentionally lower adrenaline production, reduce aggressive behavior (Calm), reconnect the brain to the higher brain functions to regain self-control (Circuit); and assists staff to recognize patterns that lead to aggression to head off a crisis before it begins (Connection). This technique is appropriate for use with people with mental health issues, developmental or intellectual disabilities, substance use disorders, criminal justice involvement, or any combination of the above.

Law enforcement and HCBS providers were invited to attend a summit held at Fort Dodge. Three providers attended the summit from CROSS Region. A later workshop was held to identify providers interested in staff development in C3 De-escalation. Two providers showed interest but could not commit staff time to the project.

Community Enrichment

Mental Health First Aid (MHFA)

The Region sent four individuals to become trainers of MHFA. They all completed and passed the course in Adult MHFA in October 2017. They have since provided seven classes to eighty-eight individuals.

Date	MHFA Version and Location	# Participants
2/1/17 to 2/8/17	Adult -3 rd Reform Church	19
2/15/17 to 2/22/17	Adult -3 rd Reform Church	20
3/25/2017	Adult – Public	7
3/29/2017	Adult – Public	5
4/4/17	Adult – Pine Rest Health Center	17
5/4/2017	Adult – Public Health Staff	6
6/8/17	Adult -	14

The NAMI Initiative

A Regional goal is to develop a NAMI presence within the Region to offer supports and education in the form of trainings and development of a chapter to families, friends, and individuals experiencing mental illness. Iowa NAMI underwent some major changes in FY 17 but we were able to arrange a Family to Family train the trainer in April of 2017. There were eight participants and graduates. The region has assigned staff to work on the development of a NAMI chapter and further trainings. The new trainers have conducted seven classes since graduation.

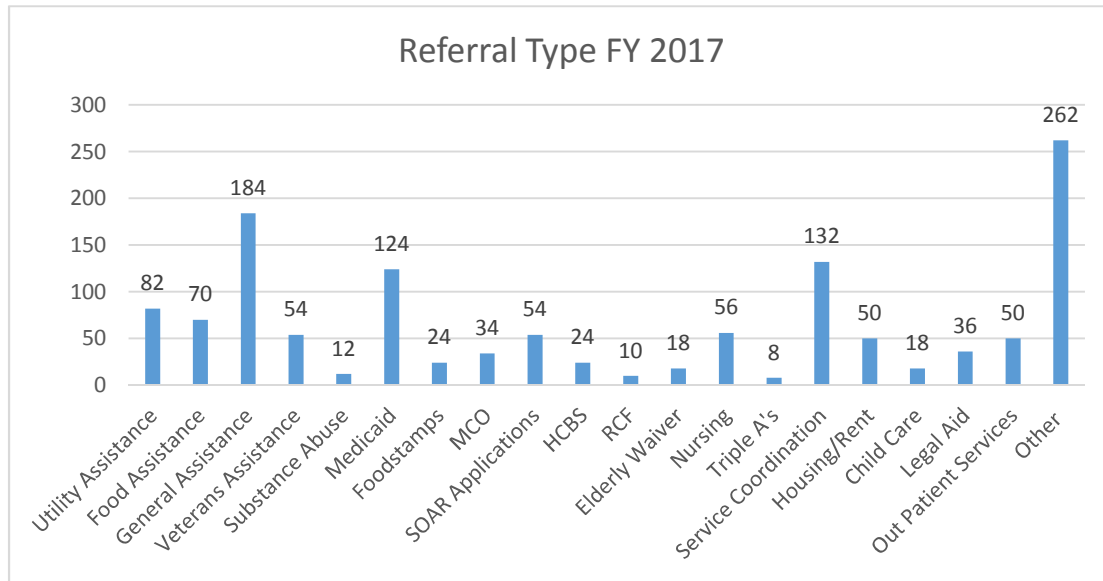
Resource and Referral

The Region provides services to our communities that do not appear in standardized reports. One of the critical services we perform is Service Coordination for our member counties. Rural communities no longer have local DHS departments in each county. Many rural residents do not have computers, internet or need assistance in completing applications. The regional offices fill this gap.

Service coordinators are in each member county to improve access for residents. There were a total of 1,302 resource/referral and service coordination contacts throughout the region. Of the 1,302 referrals 132 had service coordination needs. Referrals came from providers, Integrated Health Homes, Public Health, Hospitals, Churches, law enforcement, prisons, and other regions. Their primary needs included service coordination to determine funding eligibility for group care, Supported Community Living (SCL), transportation, rent subsidy, housing, vocational supports, payee services, benefits issues-including Social Security Outreach Access & Recovery (SOAR), connecting to an IHH, and needs assessments.

The 1,170 referrals did not require care coordination but were for resource and referral. The coordinators processed 54 SOAR applications, 124 Medicaid applications, 24 food stamp applications, 184 referrals to general assistance and 82 utility assistance referrals.

Graph C. The following graphs illustrate the intake/referral by type.



Statewide Outcomes (Quality Service Development & Assessment, QSDA)

QSDA through regional collaboration facilitates a statewide standardized approach to the development and delivery of quality MH/DS services.

I. QSDA Scope

The Regions have charged QSDA with the following responsibilities:

- Facilitate the implementation of service delivery models--Learning Communities, multi-occurring, culturally-capable, evidence-based practices, research-based practices and trauma-informed care.
- Work to ensure that Providers are utilizing Evidence Based Practices, Research Based Practices and Promising Practices.
- Identify and collect Social Determinant Outcome data.
- Work to create a Value-Based Service Delivery System utilizing performance/value-based contracts.

II. QSDA Mission and Values/Guiding Principles

- **QSDA Mission Statement:** QSDA is a group of stakeholders facilitating a statewide standardized approach to the development and delivery of quality MH/DS services measured through the utilization of outcome standards.
- **QSDA Values/Guiding Principles:**
 - All services should be the best possible.
 - Service Philosophy is based on the 5 Star Quality Model-- will always strive to achieve the highest degree of community integration as possible.
 - We have identified the need and value in providing disability support services in the person's home community. We believe individuals with disabilities have the same basic human needs, aspirations, rights, privileges, and responsibilities as other citizens. They should have access to the supports and opportunities available to all persons, as well as to specialized services. Opportunities for growth, improvement, and movement toward independence should be provided in a manner that maintains the dignity and respects the individual needs of each person. Services must be provided in a manner that balances the needs and desires of the consumers against the legal responsibilities and fiscal resources of the Region.
 - We want to support the individual as a citizen, receiving support in the person's home, local businesses, and community of choice, where the array of disability services are defined by the person's unique needs, skills and talents and where decisions are made through personal circles of support, with the desired outcome a high quality of life achieved by self-determined relationships.
 - We envision a wide array of community living services designed to move individuals beyond their clinically diagnosed disability. Individuals supported by community living services should have community presence (characterized by blending community integration, community participation, and community relationships).
 - Through the use of Evidence Based Practices, (EBP) and Research Based Practices, (RBP), Regions will continually strive to improve service quality.
 - Activities must be meaningful.
 - Any task or work completed must be meaningful. That is, it should contribute to delivering quality services.
 - Will ensure the use of standardized/efficient practices.
 - Work to establish a single data entry process.
 - Will work to ensure that outcome measures align.
 - Coordinated training process.
 - QSDA structure, projects and processes shall be based on a philosophy of accommodation and flexibility.
 - Utilize website to organize resource information, data, activities, training and process tracks.

III. Strategic Action Plan

The following projects define the FY 18 Strategic Action Plan. The FY 18 Plan, in addition to identifying new tasks, is also a continuation and expansion of a number of FY 17 projects. Projects are grouped within four Strategic Areas: Service Development, Service Delivery, Service Assessment and System Infrastructure.

- **Service Development**

- Urban-Rural Learning Community Development
 - Facilitate development of Learning Communities for legislated EBPs, including TI/COD/CC with service delivery team.
 - Coordinate with ISCA Training Committee on state-wide trainings involving QSDA initiatives.
 - Support collaboration among CEOs and Regions to address mutual interests where possible.
 - Work on collaboration with the statewide QSDA Service Assessment team for mutually beneficial services.
- Develop a Statewide Trauma-Informed Care trainer network.
 - Develop a TI Training Network with the Lincoln NE model to support a unified, consistent and sustainable TI training model statewide.
 - Identify costs and funders for this model.
 - Work collaboratively with CEOs and Providers to support this model in Regions.
- Develop an Integrated Co-Occurring Practice Model
 - Coordinate efforts with CEOs, ITAIC, DHS and IDPH.
 - Develop a state-wide training in cooperation with the Service Delivery Team
 - Populate the QSDA website with Integrated Co-Occurring Care resources.
- Continue QSDA Website development of Service Environment information.
 - Continue to develop tool kit/resource directory for Trauma Informed Care.
 - Develop tool kit/resource directory for Integrated Co-Occurring Disorders.
 - Develop tool kit/resource directory for Cultural Competency.

- **Service Delivery Work Group**
 - Support utilization of Evidence-Based Practices, Research-Based Practices, Best Practices and Promising Practices.
 - Coordinate training and supports, including in house expertise for Supported Employment, Permanent Supportive Housing and Co-Occurring Disorders.
 - Provide C3 De-escalation training for direct support staff and Providers.
 - Measure effectiveness of Evidence Based Practices, Research Based Practices, Best Practices and Promising Practices, including but not limited to: Supported Employment, Permanent Supportive Housing and Co-Occurring.
 - Emphasis through training and supports on Outcomes-positive results with individuals.
 - Assist Agencies in determination of fidelity.
 - Develop a statewide EBP Provider list and populate QSDA website.
- **Service Assessment Work Group**
 - Provide Outcomes training.
 - Provide Outcome Project Overview training
 - Train Regional Staff to perform data reviews
 - Train Regional Staff and Providers to utilize data to set goals.
 - Generate Outcome reports from CSN and validate accuracy.
 - Survey Providers and CEOs to establish report content
 - Develop Provider report procedure manual
 - Generate Regional report
 - Generate a statewide report
 -
 - Implement Phase II, Data Review
 - Train Regional staff
 - Review 12 months of Provider Outcome data.
 - Implement Phase III, Setting Annual goals and Develop Incentives
 - Create Agency summary from 12-month data review.
 - Establish Outcome targets and goals for next 12 months.
 - Create Provider supports to maintain and improve performance.
- **System Infrastructure**
 - Website – Populate Work Group data and resource information
 - Expand Functionality
 - Create training listing
 - Populate Work Group information
 - Initiate and Coordinate training
 - Work with the Community Services Training Committee, IACP, MCOs, and DHS to develop training tracks.
 - Coordinate train the trainer functions.

- Participate in planning and developing Value-Based Service Delivery system.

IV. FY 17 Accomplishments

- Maintained member participation.
 - QSDA has membership participation from the Regions, Providers, MCOs and DHS.
- Implemented and increased participation in the Outcomes Project
 - Currently outcomes are being entered by 181 Providers.
 - Have moved to Phase II--Data Review, Goal Setting and Incentives-- of the Outcomes Project.
 - Provided training on the Outcomes Project
- Maintained and enhanced the CSN Provider Portal.
- Training Process – Worked with the Iowa Community Services Affiliate, Regions and the Iowa Association of Community Providers to establish a process to coordinate and fund training within the QSDA scope.
- Began working with a multi-regional consortium looking at EBPs for supported housing and employment.
- Training
 - Trainings were conducted on Evidence-Based Practices, 5 star quality, value-based contracting and Trauma-Informed Care.
- A second EBP Survey was sent to Providers and the results summarized
 - Determined which EBPs were being utilized.
 - Measured EBP knowledge.
 - Looked at the level of fidelity.
- Met regularly with Regional CEOs to provide updates and recommendations.
- MCOs – had meetings with AmeriHealth and Amerigroup. Are looking at how outcome data may fit in with their reporting and evaluation needs and how data may be managed.

Value-Based Contracting

At the end of FYE2017 the Cross Region Governing Board voted to begin development of a value-based contracting system to begin the move away from fee for service reimbursement by changing the focus of reimbursement to a value-based system predicated on positive outcomes. The program will be applied to community living and community employment providers. The primary focus of the program's outcomes is to challenge participants to be self-sufficient and full participants in the community. Five-Star Quality is the guiding philosophy of the program's development.

QSDA provider outcomes data is being utilized to develop a baseline for quality indicators and will be used for ongoing data collection that will be independently verified. The outcome areas and indicators being focused on for the Value-Based Contracts are categorized as Quality, Efficiency, and Practice Transformation Indicators. The chart below is a breakout of the individual indicators.

Quality Indicators	Efficiency Indicators	Practice Transformation
Employment	Staff Retention	Staff Trainings
Community Housing	ED visits – non-medical	Evidenced Based Practices
Community Inclusion	Calls to Law Enforcement	
Access to Somatic Care	Negative Disenrollment	

The Regional Governance Board allocated \$20,000 to be used as additional incentives for improved outcomes in the indicators above. The incentive dollars a provider earns must be used for staff retention, development and/or trainings. The program will be rolled out in FYE 2018.

Collaboration

Regional collaboration with Department and medical assistance program

MHDS Regional Leadership

Regional CEOs and DHS MHDS representatives meet monthly to discuss regional issues, legislative updates, communication needs and links to other agencies. The CEO Collaborative, comprised of CEO's from all regions, participated in three workgroups with the Department, medical assistance program and at times MCOs. The workgroups were:

- **Crisis Services Workgroup:** The group worked to develop billing codes and modifiers for crisis services to enable providers of these services to begin billing Medicaid and reduce their dependency on regional funding.
- **Individuals with Complex-Needs workgroup.** The CROSS Region, as part of the CEO collaborative, participated in the DHS/MCO/Region workgroup for complex-needs individuals which led to the "red line" reporting system for MCOs and regions to communicate at the top management level when an individual is unable to find placement due to the complexity of their condition.
- **Outcomes workgroup:** This group worked to clarify the standardized outcomes regions are reporting, their relevancy to what MCOs are reporting, and validation of data being submitted.

Regional collaboration with Managed Care Organizations, community organizations

All region CEO's participate in meetings with DHS and MCOs every other month to discuss mutual concerns and needs in the delivery of services to Iowa residents. The meetings have led to workgroups in certain areas as described above.

In addition to the regularly scheduled meetings, the CROSS region has participated in weekly and monthly planning sessions for individuals with complex needs and their MCO, Integrated Health Home providers, community providers and the individual's guardian to promote a continuity of care with individualized planning and innovative supports. The Region has provided extra funding to increase staff-client ratios, vocational funding to support a client's successful completion of First Aide training, a requirement for an individual to become an exercise instructor, which is that individual's dream. The region provided training for direct care staff and supports through collaboration with the CSS region's I-START team to improve staff interaction with a client.

The region works closely with the eight hospitals and three Integrated Health Homes serving the region's residents. Our Disability Coordinators work closely with the IHH coordinators and hospital social workers to provide an array of services to keep individuals in their homes, communities and linked with family supports.

Success Story #1

A hospital social worker located in the CROSS region reached out to a disability service coordinator regarding a patient who was accessing the emergency room 2-3 times a month with complaints of anxiety. The social worker judged that the patient might be lonely, causing the anxiety. It was decided the anxiety might be alleviated if the individual had opportunities to be around other people. There was a volunteer opportunity at the hospital. However, the individual lives in the country with an elderly parent, does not drive and has a very limited social network. The elderly parent was instructed by the physician not to drive and the trolley does not travel gravel roads, which is where the patient's home is located.

The region DSC arranged for the cab to transport the patient to the hospital weekly to volunteer at the hospital. The monthly cost to the Region is about \$40.00. The hospital reports the patient has not been in the emergency department since volunteering, reducing stress on the emergency department and costs to Medicaid. A savings of approximately \$4,089 a month.

As the Region continued to assess the individual's needs, the Region added transportation to behavioral health appointments to the services, so the individual is no longer missing those appointments due to lack of transportation.

Regional collaboration with Regions, Providers, and stakeholders

Regions

The CEO Collaborative: The CEOs from all Regions meet monthly to develop a unified approach toward statewide initiatives. In January 2017 the collaborative engaged the services of Steve Day to assist the regions in determining a strategic direction for a unified, state-wide mental health system and to develop a MOU between regions clarifying how regions are working together laying out our common vision, expectations for the collaborative members, communication protocols, and outcome measurements.

February through May 2017 the regions also engaged the services of Teresa Schwabb, Arnavon Strategies, for leadership capacity development utilizing the “Adaptive Leadership” model. The training included CEOs and was also provided to regional staff to further develop leadership and team function.

On June 28, 2017, Mental Health and Disability Service (MHDS) Regions and the Iowa Law Enforcement Academy (ILEA) hosted a Crisis Prevention & Mental Health Summit Roundtable. We brought together a broad variety of professionals who don’t usually get to talk to each other to begin discussing and brainstorming ideas for improvement. We identified our goal as: Iowans with behavioral needs will be supported in their community from a public health not a public safety perspective. Collaboration was a common theme in our discussions.

- **Resource Collaborations - Training** (develop common language across stakeholder groups)
 - Mental Health First Aid (Family, Community Providers, Regions, MCOs, Law Enforcement, Hospitals)
 - Crisis Intervention Training (Community Providers – information/support, Regions, MCOs, Law Enforcement)
 - C3 De-Escalation (Community Providers, Regions, MCOs, Law Enforcement, Hospitals)
 - Trauma Informed Care (Community Providers, Regions, MCOs, Law Enforcement, Hospitals)
 - Co-Occurring (Community Providers, Regions, MCOs, Law Enforcement, Hospitals)
 - SAMHSA Emails (Community Providers, Regions, MCOs, Law Enforcement, Hospitals)
 - Police & MH Toolkit (Community Providers, Regions, MCOs, Law Enforcement)

- **Resource Collaborations – Community Supports** (continuing to build community capacity)
 - Tele Psychiatry
 - Mobile Crisis Response Teams/MH Assessment
 - Jail Diversion/Re-Entry
 - Open Bed Tracking System
 - Crisis Stabilization
 - Crisis Observation
 - Transition Homes
 - Sub-Acute Supports
 - Substance Abuse Services

The region also participates in county associations and committees through ISAC.

Iowa Community Services Association meetings

The ICSA Board represents regional community services for promoting progressive county government administration. The group meets monthly. Kathy Egbert and Tammy Harrah are representatives from CROSS Region.

Legislative Review Committee

The LRC committee reviews current legislation to make recommendations on priorities for legislative action and determine the impact potential legislation may have on the Regional MHDS system.

Systems level Collaboration

The CROSS region also collaborated with the CSS region for I-START services, Heart of Iowa Region for residential crisis services and the South Central Behavioral Health Region for NAMI trainings and the exploration of the expansion of ACT to their region.

Providers

The region encourages local provider collaboration and meets quarterly with a provider stakeholder group made up of providers within the region. All providers are welcome to attend. The group is meant to be a sounding board for the region by communicating with providers on quality improvement projects, evidenced-based practices, and region activities. The group has been focusing on development, training and reporting outcomes supported by the Quality Service Development and Assessment (QSDA) standardized approach. The region appointed a coordinator to train providers in outcomes reporting and to participate in data validation. The region will be implementing value-based contracting in FY18 as an outcome from this collaboration.

The region also tries to be responsive to the training needs of local providers and encourages providers to share trainings. Resources for Human Development (RHD), a new provider, opened their staff trainings to other providers as part of the contract with the region. They offered, Recovery Way of Thinking, Psychiatric Rehabilitation Principles, Stages of Change Theory and Motivational Interviewing, MHFA, Intro to Mental Illness and Psychopharmacology, Co-occurring Disorders, Overview of DHS Entitlements and Local Resources for Consumers, Cultural Competency, Intro to Cognitive Behavioral Treatment, Supporting Healthy Consumer Lifestyles, Trauma Informed Treatment, and Managing Escalation of Behavior. The region is training staff to become trainers in C3 De-escalation to be available for providers to use for direct-care staff.

The Region also provided additional supports for a provider working with an individual with challenging behaviors, bringing in I-START from the CSS region to work with the client and provider and providing additional training for direct-care staff.

Stakeholders

The CROSS Region supports and encourages stakeholder involvement by having a Regional Advisory Board. The Advisory Board serves as a public forum and assists in the development of regional and strategic plans and their corresponding goals and objectives. In addition to participation in plan development, the Advisory Board provides oversight through monitoring progress toward goals and objectives. Currently the Advisory Board has workgroups in the development of alternatives to incarceration for individuals with mental illness, disabilities and or substance abuse, value-based contracting for HCBS providers and crisis service needs. The Advisory Board meets quarterly during the fiscal year. The advisory group is comprised of 3 involved family members, six providers and is supported by the technical assistance committee.

In addition to an Advisory Board, the CROSS Region participates in monthly coalition meetings in each of the member counties. The coalition meetings are comprised of area community groups, hospitals, public health, schools and occasionally magistrates and Sheriff Departments. The purpose of these meetings is to share information, identify needs and issues, and develop collaboration.

The Region also participates on the DHS Transition Team which meets monthly to review and give suggestions to facilitate a successful transition from foster care for youth aging out of the system. Being involved has been crucial during this time of re-organization for both counties and the Medicaid system at large. Keeping this line of communication open has maintained some stability while processes and programs continue to undergo tremendous change and, at times, elimination.

The Region also participates in local ARC meetings on a quarterly basis, Health Fairs put on by local public health departments and hospitals, legislative luncheons, suicide prevention coalitions, Stepping Up coalitions, SIM meetings, Counterdrug task force meetings, Rotary, and local hospital community coalition meetings.